MDR Tracking Number: M5-04-0520-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution - General and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division (Division) assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. The dispute was received on 10-20-03.

The Division has reviewed the enclosed IRO decision and determined that **the requestor did not prevail** on the majority of the medical necessity issues. Therefore, the requestor is not entitled to reimbursement of the IRO fee.

Based on review of the disputed issues within the request, the Medical Review Division has determined that **medical necessity was the only issue** to be resolved. The biofreeze, electrodes and electrical stimulation 11-25-02 through 07-16-03, neuromuscular re-education, gait training and therapeutic activities 11-25-02 through 01-25-03 and office visits for dates of service 11-25-02 through 01-25-03 and office visits one weekly after 01-25-03 were found to be medically necessary. The neuromuscular re-education, gait training, therapeutic activities after 01-25-03, office visits more than one per week after 01-25-03 and therapeutic procedures, x-ray of the shoulder, myofascial release, manual traction and team conference for 11-25-02 through 07-16-03 were not found to be medically necessary. The respondent raised no other reasons for denying reimbursement for biofreeze, office visits, therapeutic procedures, neuromuscular re-education, electrodes, therapeutic activities, gait training, electrical stimulation, myofascial release, manual traction, team conference and x-ray of the shoulder.

This Findings and Decision are hereby issued this 19th day of February 2004.

Debra L. Hewitt
Medical Dispute Resolution Officer
Medical Review Division

On this basis, and pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay the unpaid medical fees in accordance with the fair and reasonable rate as set forth in Commission Rule 133.1(a)(8) plus all accrued interest due at the time of payment to the requestor within 20-days of receipt of this Order. This Order is applicable to dates of service 11-25-02 through 07-16-03 in this dispute.

The respondent is prohibited from asserting additional denial reasons relative to this Decision upon issuing payment to the requestor in accordance with this Order (Rule 133.307(j)(2)).

This Order is hereby issued this 19th day of February 2004.

Roy Lewis, Supervisor
Medical Dispute Resolution
Medical Review Division
RL/dlh

February 18 2004

Rosalinda Lopez
Texas Workers' Compensation Commission
Medical Dispute Resolution
Fax: (512) 804-4868

REVISED REPORT
Employee's middle initial added.

Re: MDR #: M5-04-0520-01
IRO Certificate No.: IRO 5055

___has performed an independent review of the medical records of the above-named case to determine medical necessity. In performing this review, ___ reviewed relevant medical records, any documents provided by the parties referenced above, and any documentation and written information submitted in support of the dispute.

The independent review was performed by a matched peer with the treating health care provider. This case was reviewed by a physician who is certified in Chiropractic Medicine.

Clinical History:
This male claimant sustained a work-related injury on ___. He was rendered unconscious and was taken to the hospital, where he was later released. A few days later, he was re-admitted to the hospital for observation and diagnostic testing. He had sustained injuries to his head (apparently neurological and psychological), whole spine, upper extremities, and lower extremities.

Disputed Services:
Biofreeze (not classified DME), office visits, therapeutic procedures, neuromuscular re-education move, electrodes, therapeutic activities, gait training, electric stimulation, myofascial release, manual traction and team conference, and X-ray of the shoulder, during the period of 11/25/02 through 07/16/03.

Decision and Rationale:
The reviewer partially agrees with the determination of the insurance carrier as follows:

Biofreeze – due to the extent of these injuries, this analgesic cream/gel, which is topically applied for pain relief, would be considered medically necessary.

Office Visits – the primary function of the treating physician is to diagnose, prescribe, and oversee the care of the claimant. Because of the number of injuries sustained, the referrals by the treating physician and the insurance carrier, and the number of Designated Doctor appointments, the claimant would require a number of visits with the treating physician for maintenance and continuity of care. Thus, all office visits initially for the eight weeks up until 01/25/03 should be considered medically necessary. Once weekly office visits beyond 01/25/03 would be considered reasonable and medically necessary. Also, usual and customary care should not exceed a two-hour office visit limit.

Therapeutic procedures – documentation failed to establish medical necessity.

Neuromuscular re-education move – medically necessary through 01/25/03.

X-ray of the shoulder – reason for x-ray not documented, therefore, not medically necessary.

Gait Training – medically necessary until 01/25/03.

Myofascial Release – not documented, therefore, not medically necessary.

Manual Traction – not documented, therefore, not medically necessary.

Team Conference – not documented as a team conference, but as a telephone conversation; thus, not medically necessary as a team conference.

Electrodes – for use with home use electrical stimulator for pain control. Due to extent of injuries, this would be considered medically necessary.

Electric Stimulation – due to extent of injuries, this would be considered medically necessary.

Therapeutic Activities – medically necessary through 01/25/03.

Guidelines listing criteria for determining which patients may benefit from functional physical medicine procedures are not currently recognized in Texas by the Chiropractic Licensing Board, the State associations, or the Practice Parameter Committees. Thus, general consensus is that the candidates for functional physical medicine is a judgment call, determined by many possible variations of clinical presentations.

In the document authored by ___ entitled "Physiotherapy and Rehabilitation Guidelines for the Chiropractic Profession", Stage 4 is the rehabilitation stage of treatment following 7 to 12 weeks of sub-acute remodeling phase.

Each clinician must depend upon his own knowledge of chiropractic and expertise in the use or modification of these materials and information. Generally, passive care is time-limited, progressing to active care.

Functional physical medicine programs are generally the choice of treatment options following a program of in-office passive modalities and/or home office and home therapeutic exercise programs. It is apparent from the treatment records that the treating physician was exploring these options prior to referral for surgical intervention.

I am the Secretary and General Counsel of ___ and I certify that the reviewing healthcare professional in this case has certified to our organization that there are no known conflicts of interest that exist between him and any of the treating physicians or other health care providers or any of the physicians or other health care providers who reviewed this case for determination prior to referral to the Independent Review Organization.

Sincerely,